

5101:3-3-262     Long-term care facility medicaid cost report.

The long-term care facility medicaid cost report must be filed in accordance with requirements set forth in rules 5101:3-3-26 ("Long-term care facility cost report filing, record retention, and disclosure requirements") and 5101:3-3-261 ("Chart of accounts for long-term care facilities") of the Administrative Code.

Appendix A of this rule is the report which must be utilized by medicaid long-term care facilities in Ohio for purposes of reporting expenditures for services recognized by the department of human services.

**FILED**  
Legislative Service Commission  
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JOINT COMMITTEE  
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SUPERSEDES  
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**INSTRUCTIONS FOR COMPLETING THE JULY 1, 1992 THROUGH DECEMBER 31, 1992  
COST REPORT FOR NURSING FACILITIES (NFS) AND INTERMEDIATE CARE FACILITIES  
FOR THE MENTALLY RETARDED (ICFS-MR)**

Pursuant to new legislation effective July 1, 1991 through June 30, 1993, the reimbursement methodology for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) was changed to a prospective basis. Due to the effective date of this change, cost reports will be completed for six-month periods ending June thirtieth and December thirty-first. The changes to the July 1, 1992 through December 31, 1992 ODHS 2524 Medicaid cost report are as follows:

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**MAJOR CHANGES IN THE JULY 1, 1992 THROUGH DECEMBER 31, 1992 COST REPORT**

The significant changes in the July 1, 1992 through December 31, 1992 cost report are as follows: Social security numbers will now be required on Schedule C-1, C-2 and C-3; Schedule B line 49 has been changed to Respiratory Therapist and line 56 has been changed to Social Services/Pastoral care; Attachment number 9 has been discontinued.

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**General Instructions**

**Reasonable Cost**

Reasonable cost of any service is determined in accordance with regulations which establish the method or methods to be used and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. State law, departmental regulations codified in accordance with state law, and the principles of reimbursement for provider costs with related policies described in the Health Care Financing Administration Publication 15-1 (HCFA 15-1), also known as HIM-15, and 42 CFR Part 413, establish guidelines and procedures to be used in determining reasonable costs for services rendered by NFs and ICFs-MR. Departmental regulations regarding the reasonable and allowable costs are contained in Ohio Administrative Code (OAC) rules 5101:3-3-17 through 5101:3-3-28. Please read all instructions carefully before completing the forms.

**Routine Services**

Administrative Code rule 5101:3-3-11 lists covered services for all providers who serve long-term care residents. This rule outlines the costs for services reimbursed through the cost reporting mechanism of NFs and ICFs-MR and the costs directly billed to Medicaid by service providers other than NFs and ICFs-MR.

**Filing the Medicaid Cost Report**

All facilities are required to file a cost report in duplicate. The deadline for submission of the cost report is ninety days after the end of the reporting period. The reports shall cover six-month periods ending June thirtieth and December thirty-first of each year or the period of Medicaid certification if less than six months unless another period has been designated by the Department.

**Accounting Basis**

Cost data submitted must be on the accrual basis, except for county operated facilities which operate on a cash method of accounting.

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**Cost Report Forms**

The cost report is designed to provide statistical data, financial statements adjusted to the allowable Medicaid cost, and disclosures as required by federal and state rules. Attachments to the cost report are part of the documents which are required to file a complete cost report.

|                            |   |
|----------------------------|---|
| Schedule A                 | Statistical data and identification   |
| Schedule A-1               | Summary of Inpatient Days   |
| Schedule A-1 (page 2 of 2) | Summary of Medicaid Days for Transferred Beds from Another Provider and Beds New to the Medical Assistance Program                  |
| Schedule A-2               | Determination of Customary Charges for Routine Services   |
| Schedule A-2a              | Determination of Medicare Part B Costs to Offset  |
| Schedule A-3               | Summary of Costs  |
| Schedule B                 | Direct Cost   |
| Schedule C                 | Administrative and General Costs  |
| Schedule C-1, C-2, and C-3 | Disclosures of information about compensation to administrators, owners, relatives, and cost of services from related organizations |
| Schedule D                 | Cost of Ownership Trial Balance   |
| Schedule D-1               | Analysis of Property, Plant and Equipment   |
| Schedule E                 | Balance Sheet   |
| Schedule E-1               | Return on Equity Capital of Proprietary Providers   |
| Schedule F                 | Certification by Officer of Facility  |
| Attachment 1               | Revenue Trial Balance   |
| Attachment 2               | Adjustment to Trial Balance   |
| Attachment 3               | Copies of the provider's trial balance, depreciation schedules, home office trial balance, and other documents                      |
| Attachment 4               | Cost Allocation - Statistical Basis   |
| Attachment 5               | Medicaid Cost Report Supplement   |
| Attachment 6               | Paid Non-Medicaid Leave Days  |
| Attachment 7               | Nurse Aide Training   |
| Attachment 8               | Overpayment Recoupment Fund Distribution Priorities Information   |

**Sequence and Procedures for Completing Cost Reports**

1. Complete ODHS 2524, Schedule A, top section
2. Complete ODHS 2524, Schedule A-1
3. Complete ODHS 2524, Schedule A, statistical data line 1 through line 8
4. Complete ODHS 2524, Attachment 2
5. Complete ODHS 2524, Attachment 1
6. Complete ODHS 2524, Schedule A-2
7. Complete ODHS 2524, Schedule A-2a
8. Complete ODHS 2524, Attachment 7
9. Complete ODHS 2524, Schedule B (columns 1 through 5)
10. Complete ODHS 2524, Attachment 6
11. Complete ODHS 2524, Schedule C (columns 1 through 5)
12. Complete ODHS 2524, Schedule C-1
13. Complete ODHS 2524, Schedule C-2
14. Complete ODHS 2524, Schedule C-3
15. Complete ODHS 2524, Schedule D-1
16. Complete ODHS 2524, Schedule D
17. Complete ODHS 2524, Attachments 4 and 5
18. Complete ODHS 2524, Schedules B,C,D (columns 7 and 8)
19. Complete ODHS 2524, Schedule E
20. Complete ODHS 2524, Schedule E-1
21. Complete ODHS 2524, Schedule A-3
22. Complete ODHS 2524, Attachment 3
23. Complete ODHS 2524, Attachment 8
24. Complete ODHS 2524, Schedule F, certification

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## Explanation of Procedures

### 1. ODHS 2524, Schedule A

**Identification** — The name of the facility and address, county, provider number, federal ID number. Include addresses of owner of real estate and owner (operator) of business.

**Type of Control** — Check the category that describes the nature of the ownership or auspices under which the institution is operated.

**Type of Facility** — Indicate the type of facility in accordance with licensure standards filed with the Ohio Department of Health (ODH). If the facility indicated is a separate part of another facility, indicate with a check in the appropriate block. Remember, effective October 1, 1990, OBRA of 1987 changed ICFs, SNFs, and ICF/SNFs to NFs (nursing facilities).

**Period Covered by the Cost Report** — This is a six-month period ending December thirty-first unless another period has been designated by the department. New facilities must indicate the time period of actual costs included.

### 2. ODHS 2524, Schedule A-1

This schedule includes quarterly subtotals.

Please foot the subtotals on lines 4 and 8 with the grand total on line 9.

#### Page 1 of 2

**Column 1** — Record monthly those beds which are certified by the Ohio Department of Health.

**Column 2** — Record monthly the authorized skilled, intermediate, mental retardation and pending Medicaid days.

**Columns 3 and 4** — Record the total monthly reimbursable leave days for Medicaid residents. See OAC Rule 5101:3-3-03 regarding reimbursable leave days.

**Column 5** — Total of columns 2, 3, and 4. Carry the total on line 9 forward to ODHS 2524, Schedule A, line 7.

**Column 6, 7, and 8** — Record monthly the bed days for non-Medicaid eligible residents. Leave days should not be included in these columns. Carry the totals to the appropriate column of ODHS 2524, Schedule A-2, line 12.

**Column 9** — Record monthly the inpatient/resident days for all residents. This column is the sum of columns 5 through 8. The day of admission, but not the day of discharge, is to be counted. When a resident is admitted and discharged on the same day, this must be counted as one inpatient/resident day. Inpatient/resident days include those leave days which are reimbursable under the Ohio Medicaid program. Private leave days are not to be included in inpatient/resident days. Carry the total on line 9 forward to Schedule A, line 4.

- Effective July 1, 1989, payment for medically necessary leave days and limited absences was changed to 50% of the Medicaid rate for ICFs, SNFs, and ICF/SNFs. Beginning July 1, 1989, these facilities must also report each medically necessary leave day and limited absence as 50% of an inpatient/resident day. Please refer to OAC Rule 5101:3-3-03 as contained in LTCTL 89-5 for details.

#### Page 2 of 2

Complete Schedule A-1, page 2 of 2, to specify the number of Medicaid days directly related to beds which were transferred from another provider or new to the Medical Assistance Program. Column 9 line 9 should equal column 5 line 9 of Schedule A-1, page 1 of 2. Do not complete Schedule A-1 page 2 of 2 unless beds were transferred from another provider or new to the Medical Assistance Program. Complete a separate Schedule A-1 page 2 of 2 for each occasion beds were transferred from another provider or were new to the Medical Assistance Program during the cost report period. If beds were transferred or added new to the program more than once, also submit an additional Schedule A-1 page 2 of 2 to summarize and total all occasions.

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3. ODHS 2524, Schedule A: Statistical Data

This section must be completed in all instances per the following instructions:

**Lines 1 and 2 — Licensed Beds:** Enter number of beds licensed by ODH. Temporary changes because of alterations, painting, etc., do not affect bed capacity.

**Line 3 — Total Bed Days:** This amount is determined by the number of days in the reporting period. Take into account increases or decreases in the number of beds licensed and the number of days elapsed since increases or decreases.

**Line 4 — Total Inpatient Days:** Obtain the answer from ODHS 2524, Schedule A-1, column 9, line 9.

**Line 5 — Percentage of Occupancy:** This amount is the proportion of total inpatient/resident days to total bed days during the reporting period. Obtain the answer by dividing line 4 by line 3.

**Line 6.1 — Administrative and General Allowable Days:** For computing administrative and general costs, ODHS will not recognize an occupancy rate of less than 85%. If percentage of occupancy is 85% or more, enter the number of inpatient/resident days stated on line 4. If percentage of occupancy is less than 85%, enter 85% of the number of bed days stated on line 3. (See OAC Rule 5101:3-3-171). Providers on the Medicaid program less than 6 months, also see OAC Rule 5101:3-3-171.

**Lines 6.2 — Property Ownership Allowable Days:** For computing property ownership costs, ODHS will not recognize an occupancy rate of less than 95%. If percentage of occupancy is 95% or more, enter the number of inpatient/resident days stated on line 4. If percentage of occupancy is less than 95%, enter 95% of the number of bed days stated on line 3. (See OAC Rule 5101:3-3-171). Providers on the Medicaid program less than 6 months, also see OAC 5101:3-3-171.

**Lines 7 and 8 — Total Patient Days and Utilization:** This refers to residents who receive benefits under the Title XIX (Medicaid) program. Bring total from Schedule A-1, column 5, line 9, forward to Schedule A, line 7.

**Line 9 —** Indicate if you serve ten or less Medicaid recipients at all times.

4. ODHS 2524, Attachment 2

**Columns 2 and 3, lines 1 through 23 —** Enter appropriate adjustments as necessary to comply with HCFA Publication 15-1, federal regulations, state laws, and Ohio Medicaid program regulations. Items included on lines 11-23 must have attached supportive detail.

**Column 4, lines 1 through 23 —** Sum of columns 2 and 3.

**Column 5, lines 1 through 5 —** In column 5, cross-reference adjustments to Schedules B, C, and D by entering appropriate schedule line and number. Carry figure in column 4 forward to appropriate line on ODHS 2524, Schedules B, C, and D, column 4.

**Note:** In some cases (e.g., cash discounts) revenue does not apply to a specific account and a reference has not been provided. In these cases, the adjustment should be made on the appropriate line item of the proper expense schedule and a schedule and line reference given.

After completing Attachment 2 and entering adjustments to expenses Schedules B, C, and D, column 4, adjusted total expenses (Schedules B, C, and D, column 5) can be computed.

5. ODHS 2524, Attachment 1-Revenue Trial Balance

**Column 1 —** Enter total revenue for each line item.

**Column 2 —** Enter any adjustments; attach detail.

**Column 3 —** Column 1 plus or minus adjustments in column 2.

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**6. ODHS 2524, Schedule A-2**

This schedule is designed to compute customary charges to non-Medicaid residents for all services defined as routine by Medicaid. If there is an additional charge to non-Medicaid residents for physical therapy, occupational therapy, speech therapy, medical supplies, laundry (excluding dry-cleaning charges), or any other item(s) considered by Medicaid as routine services, list revenue from non-Medicaid residents only on the appropriate lines below.

**Lines 1a through 6a** — List gross charges for all residents by payer type. Gross charges must be reported from a uniform charge structure that is applicable to all residents. Total of column 9 must equal revenue reported on attachment number 1 "Revenue Trial Balance".

**Lines 1b through 6b** — These lines represent the ratio of the individual revenue reported in line 1a divided by the total revenue reported on line 1a column 9. Report the percentages by payer type and carry the decimal to four places. The total of all percentages must equal 100%.

**Line 7** — Total all revenue reported on lines 1a through 6a.

**Line 8** — Reclassify Medicare Part B revenue reported on line 7 column 3 to the appropriate payer type.

**Line 9** — Enter room and board revenue reported from attachment number 1 in the appropriate column. Revenue reported on this line must equal revenue reported on attachment number 1.

**Line 10** — Enter other routine revenue from attachment number 1 in the appropriate column. Revenue reported on this line must equal revenue reported on attachment number 1.

**Line 11** — Total revenue by adding lines 7, 8, 9, and 10. Column 7 is a subtotal for columns 4, 5, and 6 only. Total revenue must equal total revenue reported on attachment 1 line 17.

**Line 12** — Enter non-Medicaid inpatient/resident days from schedule A-1 line 9 columns 6, 7, and 8.

**Line 13** — Enter other non-Medicaid leave days from attachment number 6.

**Line 14** — Total lines 12 and 13.

**Line 15** — Divide the total revenue reported on line 11 by the total non-Medicaid days reported on line 14.

**7. ODHS.2524 Schedule A-2a**

This schedule is designed to determine the amount of Medicare Part B costs to offset on the cost report by cost center to comply with OAC Rule 5101:3-3-23 (K).

**Section A — Direct Costs**

**Line 1** — Enter the ratio of Medicare Part B charges where the primary payer is Medicaid from schedule A-2 column 2 lines 1b, 2b, 3b, 4b, 5b, and 6b. These ratios must be entered in the corresponding column, i.e., physical therapy percentage from schedule A-2 column 2 line 1b must be entered on line 1 column 2 physical therapy.

**Line 2** — Enter the corresponding direct care costs from schedule B column 3 in the appropriate column. See medical supplies worksheet on schedule A-2a for columns 5 and 6 information.

**Line 3** — Multiply line 1 times line 2. The result is the amount of direct care costs to offset on the appropriate line on schedule B column 4. Offset the result on schedule B on the same line where the costs are reported.

**Section B — Ownership Costs**

**Line 4** — Enter the square footage of each department listed. The total square footage must equal the square footage statistics reported on the Medicare cost report. If square footage does not apply go to Section C.

**Line 5** — This line represents the ratio of each individual column divided by the total square footage reported in column 8. Total of all percentages must equal 100%.

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**Line 6** — Multiply line 1 times line 5.

**Line 7** — Enter total ownership costs from schedule D line 10 column 3.

**Line 8** — Multiply line 6 times line 7. The result is the amount of ownership costs to offset on schedule D line 1 column 4.

**Line 9** — Enter total renovation costs from schedule D line 23 column 3.

**Line 10** — Multiply line 6 times line 9. The result is the amount of renovation cost to offset on schedule D line 22 column 4.

**Section C — Indirect Cost: Administrative and General**

**Line 11** — Enter total administrative and general costs reported on schedule C line 30 column 3 less the total schedule C lines 10, 11, 12, and 13.

**Line 12** — Enter the sum of the totals reported on schedule B line 72 column 3, schedule C line 30 column 3, schedule D line 10 column 3, and schedule D line 10 and 23 column 3.

**Line 13** — Divide line 11 by line 12.

**Line 14** — Enter direct care costs to offset from line 3 column 8 above.

**Line 15** — Multiply line 13 times line 14. The result is the amount of indirect costs to offset on schedule C line 29 column 4.

**Medical supplies worksheet** - Medical supplies reported on the Medicaid cost report are compared to three areas, on the Medicare cost report. In order to offset the appropriate amount of Medicare Part B revenue, the following is a breakdown of the accounts necessary for proper offset:

**Medical supplies non-billable to Medicare** - This line represents medical supplies expenses that you are unable to bill to Medicare as an ancillary item on the Medicare cost report.

**Medical supplies billable to Medicare** - This line represents medical supplies expenses that you are able to bill to Medicare as an ancillary item on the Medicare cost report.

**Enteral feeding expense** - This line represents expenses for Parenteral Nutritional (P.E.N.) billings to Medicare. Only the expenses for enteral feeding are reported on this line.

**Total medical supplies** - Must equal Schedule B line 10 column 3 of the Medicaid cost report.

**Failure to complete schedule A-2a will result in all Medicare Part B revenue to be offset against direct care expenses on schedule B line 60.**

**8. ODHS 2524, Attachment 7**

**Sections A and B**

Complete sections A and B for nurse aide training program income and the number of nurse aides in your facility.

**Section C — Nurse Aide Training Statistical Information**

**Line 3** — Complete the number of nurse aides that have completed training program by the various sources on 12-31-92.

**Line 4** — Complete the number of nurse aides that have dropped out of the training program by the various sources on 12-31-92.

**Line 5** — Line 13 + line 14.

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Line 6 — Report the total number of state approved nurse aides on your payroll on 12-31-92.

Line 7 — Report the total number of state approved nurse aides, other than line 6, on 12-31-92.

9. ODHS 2524, Schedule B (Columns 1 through 5)

This schedule is comprised of a list of accounts which encompass direct costs designated by ODHS as dietary supplies and expenses, medical and habilitation supplies, prior authorized medical equipment, incontinence and other supplies, physician services, nurse aide training, nursing and habilitation/rehabilitation, payroll taxes for dietary and nursing personnel, utility costs and property taxes.

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "other" category and provide supporting documentation.

**Explanation of Schedule B Columns:**

|                 |   |
|-----------------|---|
| Columns 1 and 2 | Expenses rounded to the nearest dollar for the given item.  |
| Column 3        | Total of Columns 1 and 2.   |
| Column 4        | Cost adjustments in dollars of increase or decrease of each line item. Any entries in this column which are not from Attachment 2 must be fully explained on an attachment sheet. |
| Column 5        | Total of line items in columns 3 and 4.   |
| Columns 6, 7, 8 | Allocations and or other non-reimbursable cost centers. If columns 6, 7, and 8 apply to your cost, complete them after completing Attachments 4 and 5 (Procedure 17).             |
| Line 57         | This line reflects the costs of Qualified Mental Retardation Professionals (QMRPs) who acquire and maintain federal qualifications as established in 42 CFR Part 483.             |

10. ODHS 2524, Attachment 6

This attachment is for the reporting of paid non-Medicaid leave days. Record monthly the non-Medicaid leave days paid for by anyone other than ODHS. Paid non-Medicaid leave days are hospital, therapeutic or any other leave days paid for by a non-Medicaid resident. Non-Medicaid leave days are counted as inpatient days proportionate to the non-Medicaid per diem rate paid.

11. ODHS 2524, Schedule C (Columns 1 through 5)

This schedule is comprised of a list of accounts which include administrative and general services costs as designated by ODHS. Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "other" category and provide supporting documentation.

**Explanation of Schedule C Columns:**

|                 |   |
|-----------------|---|
| Columns 1 and 2 | Expenses rounded to the nearest dollar for the given item.  |
| Column 3        | Total of Columns 1 and 2  |
| Column 4        | Cost adjustments in dollars of increase or decrease of each line item. Any entries in this column which are not from Attachment 2 must be fully explained on an attachment sheet. |
| Column 5        | Total of line items in columns 3 and 4.   |
| Columns 6, 7, 8 | Allocations and or other non-reimbursable cost centers. If columns 6, 7, and 8 apply to your cost, complete them after completing Attachments 4 and 5 (Procedure 17).             |

**Note # 1:** When an account name is on more than one schedule, the amount should be subdivided for each schedule, e.g., fringe benefits for office personnel are on Schedule C, while fringe benefits for nurses are on Schedule B.

**Note # 2:** Adjustments have to be made to home office costs on Schedule C, line 7, column 4, which reclassify costs to the appropriate cost centers on Schedule B, C (line 1 only), and D. Schedule C, line 1, must be broken out of home office costs and reported separately in order to apply salary screens as delineated in OAC Rule 5101:3-3-20. The remaining administrative home office costs can remain on Schedule C, line 7, since the entire schedule is reimbursed under the A&G allowance.

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**12. ODHS 2524, Schedule C — 1**

This schedule must be completed for any person(s) claiming reimbursement as an administrator. This includes an owner or owners who serve as the administrator or who claim reimbursement for a management, financial advisory, or counseling function which would be considered within the duties of an administrator. (See OAC Rule 5101:3-3-20).

**Identifying Information** — Complete top three lines with appropriate information.

**Line 1 — Base Percentage Allowance:** Enter 100%

**Line 2 — Work Experience:** Years of work experience in a related work area are used in computing the years of experience up to a maximum of 10 years.

**Line 3 — Educational Experience:** Enter the number of years of formal education beyond high school. A maximum of six years may be claimed if a baccalaureate degree has been obtained.

**Line 3.1** — Check appropriate box for completion of baccalaureate degree.

**Line 4 — Other Duties Performed:** Four additional points may be claimed for each duty performed which is not ordinarily considered part of the responsibility of the administrator. A maximum of four additional duties may be claimed. Provide documentation supporting the extra duties.

**Line 5 — Geographic Location:** Add 6% if the facility is in one of the following counties:

|          |          |            |        |
|----------|----------|------------|--------|
| Cuyahoga | Hamilton | Mahoning   | Stark  |
| Franklin | Lucas    | Montgomery | Summit |

**Line 6 — Ownership Points:** Add ten points if the administrator is also an owner.

**Line 7 — Subtotal:** Total of lines 1 through 6.

**Line 8 — Allowable percentage:** Enter the lesser of 150% of the base allowance or line 7.

Each administrator must detail the following for each facility in which he/she receives compensation: facility name and number of beds, administrator license number, dates of employment, hours and percentage of time worked weekly at the facility, amount of compensation and the schedule and line number on which it is reported.

List all compensation actually paid to employed persons who perform duties as administrators. Report compensation for duties other than administrative in other cost centers. Extra duty points for non-administrative compensation must be reported on Schedule C-1, line 4.

**13. ODHS 2524, Schedule C-2**

All items contained within this schedule must be completed or noted N/A if not applicable. Failure to comply will result in the cost report being considered a "no filing" and will delay processing and subsequent rate change. (See OAC Rule 5101:3-3-20 and HCFA Publication 15-1 Chapter 900.)

Detail owner's and/or relative's compensation. Specify name and social security number of person(s) claiming compensation, relation to owner(s), duties performed, years of experience in this field, dates of employment in this reporting period, number of hours worked in facility during the week and corresponding percentage of time worked at this facility, the schedule, line number, and amount claimed for each person listed on the cost report.

The following are relationships to be considered:

- (1) Husband and wife
- (2) Natural parent, child, and sibling
- (3) Adopted child and adoptive parent
- (4) Stepparent, stepchild, stepbrother, stepsister
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, and brother-in-law
- (6) Grandparent and grandchild

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Actual compensation claimed for relatives is subject to a special test of reasonableness based upon the appropriate step of an equivalent civil service classification. Compensation claimed must be for necessary services and related to resident care. Services rendered and compensation claimed must be reasonable based upon the time spent in performing the duty and the duty which is being performed.

14. ODHS 2524, Schedule C-3

Complete per instructions on the form.

15. ODHS 2524, Schedule D-1

Upper Portion:

Column 1 — Enter date of acquisition of each class of assets.

Column 2 — Enter balances recorded in the facility's books of accounts at the beginning of the reporting period. Before entering the amounts, make all necessary adjustments to be in compliance with the Medicaid program. Figures must be based on the historical cost of the asset. In case of a donated asset, fair market value at the time of the donation will be used.

Column 3 — Enter additions or reductions to the appropriate category during the reporting period.

Column 4 — Cost at end of period is the sum of columns 2 and 3.

Column 5 — Enter in each category the accumulated depreciation claimed. Be sure to complete the question at the bottom of the schedule.

Column 6 — Balance at end of period is column 4 less column 5.

Column 7 — Enter for each category the depreciation expense claimed for reimbursement in this reporting period.

Lower Portion:

The renovations section is only completed by facilities which have incurred expense for renovations reimbursable under OAC Rule 5101:3-3-17 and 5101:3-3-22.

Columns 1 through 7 — See instructions for Columns 1 through 7 above.

Column 8 — Enter any interest paid for renovations for each period as appropriate.

Column 9 — Total columns 7 and 8 (Totals of Columns 2, 4, and 5 transfer to Schedule E)

16. ODHS 2524, Schedule D (Columns 3 through 5)

Explanation of Schedule D Columns:

Column 3 Expenses rounded to the nearest dollar for the given item.

Column 4 Cost adjustments in dollars of increase or decrease of each line item. Any entries in this column which are not from Attachment 2 must be fully explained on an attachment sheet.

Column 5 Total of line items in columns 3 and 4.

Column 6,7,8 Allocations and or other nonreimbursable cost centers. If columns 6, 7, and 8 apply to your cost, complete those columns after completing Attachments 4 and 5 (Procedure 17).

Column 4 may be used to delete depreciation for costs paid or reimbursed by government agencies in order to comply with the provisions of Am. Sub. H.B. 694 and OAC Rule 5101:3-3-22.

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